# EXHIBIT 6

Guardian

**BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA**
Mail Only: Claims Service and Solutions Group
PO Box 981593, El Paso, TX 79998-1593
*A wholly owned stock subsidiary of and administrator for*
*The Guardian Life Insurance Company of America, New York, NY*

## Disability Claim Instructions | For Assistance, Call Toll Free 1-888-275-7473

| Wairimu Waiyaki | Z4834040 |
|---|---|
| Name | Policy Number(s) |

To be used with policies issued by: Berkshire Life Insurance Company, Berkshire Life Insurance Company of America, or The Guardian Life Insurance Company of America.

This claim will be managed by Berkshire Life Insurance Company of America, a wholly owned stock subsidiary of and administrator for The Guardian Life Insurance Company of America.

When we refer to "Claimant" in these Instructions, we recognize that an individual with the appropriate legal authority may be completing and signing these forms on behalf of the Claimant. Illegible or incomplete responses, or altered forms, may cause delays in processing the claim. All forms should be returned promptly so that the claim evaluation process can begin. A copy of the completed forms and all other supporting documentation should be retained by the Claimant for his or her own records.

**FORM COMPLETION INSTRUCTIONS:**

1. **Authorization to Obtain Information:** The Claimant must complete this form in full. Please provide your date of birth where indicated at the top right section of the Authorization. Please sign and date the bottom of the Authorization. Altered forms cannot be accepted.

2. **Disability Claimant's Statement and Description of Occupation:** The Claimant must complete this form in full. Please be sure to sign and date the Disability Claimant's Statement and Description of Occupation form on the last page of the form. If you require additional space to complete your responses, please feel free to submit such information on additional sheets/pages.

3. **Physician's Statement:** The Physician DIRECTLY in charge of the Claimant's care must complete this statement in full and sign and date the form at the bottom of page two. Please insert your date of birth at the top of the form prior to providing it to your Physician.

4. **Direct Pay Enrollment and Authorization:** To simplify your experience, we offer Direct Pay, a service which provides for the direct deposit of eligible disability benefit payments into your checking or savings account. Compared to traditional paper checks and postal delivery methods, Direct Pay is the more convenient and faster alternative. To enroll, please complete the Direct Pay Enrollment and Authorization form included with this package.

If there is additional information that will assist us in evaluating the claim, please be sure to include it.

**The Claimant is responsible for completing the Authorization to Obtain Information form and the Disability Claimant's Statement and Description of Occupation form, as well as ensuring the completion of the Physician's Statement by his or her physician without expense to Berkshire Life Insurance Company, Berkshire Life Insurance Company of America, or The Guardian Life Insurance Company of America. Please mail the original forms to:**

Berkshire Life Insurance Company of America
Claims Service and Solutions Group
PO Box 981593
El Paso TX 79998-1593

For express mail please use:

5951 Luckett Ct, Bldg A
El Paso, TX 79932

You may also return forms via email to diclaims@glic.com or via fax at (413) 395-5984.

Insured: Wairimu Waiyaki
Policy No. Z4834040

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## Disability Claimant's Statement and Description of Occupation
For Assistance, Call Toll Free 1-888-275-7473

Please answer **every** question and complete the authorization. An incomplete form or authorization could delay the processing of your claim. If more space is needed, please provide applicable information on additional pages.

Wairimu Waiyaki — ☑ Single ☐ Married
Name of Insured | Date of Birth | Height | Weight

302 Perimeter Ctr N. Apt 2324
Atlanta, GA, 30346
Present **Residence** Address: No. and Street, City, State and Zip Code | Mailing Address if different

(Home) (Work) 678-469-1124 (Cell) (Fax)
Telephone #s

XXX-XX- 3205
E-mail Address | Social Security #

1. **Nature of Disability** (Complete A **or** B)

A. ☐ **Injury** – Description of Accident and Resulting Injuries _____

Place Injury Occurred (Name and Address) _____

Date and Time of Injury _____

Was a report filed? ☐ Yes ☐ No If Yes, please provide copy of report.

Name(s) of Witness(es) _____

Any other injury(ies) in past five (5) years? ☐ Yes ☐ No If Yes, please provide date(s) and nature of injury(ies).

B. ☑ **Sickness** - Nature of Sickness Depression & Anxiety

Date of First Symptoms December 2022 Have you ever had the same or similar sickness? ☐ Yes ☑ No

Any other sickness(s) in past five (5) years? ☑ Yes ☐ No If Yes, please provide date(s) and nature of sickness(s).

Psoriasis

2. **Period of Disability**

A. I have not worked at all in my occupation (or occupations) due to disability from 05/01/2023 (date) to unknown (date)

B. I have worked in a reduced capacity in my occupation (or occupations) due to disability from N/A (date) to _____ (date)

C. Did your attending physician advise you to stop work altogether, or work in a reduced capacity for the dates indicated? ☑ Yes ☐ No

3. **Medical**

A. Date of first treatment by a physician (or other medical care provider) for this injury or sickness December 2022

B. Please provide the name(s) and address(es) of your primary care provider(s) for the past five (5) years:

Aleeza Parkey, Safe Haven Wellness Locust Grove, GA 30248

Dr. Ariyo Moji. Emory Healthcare 5673 Peachtree Dunwoody Rd, GA 30342

Dr. Ofodile Olayide, 4800 Olde Town Pkwy, Marietta GA, 30068

C. List the name, address, telephone number, and dates of treatment of all treating providers for this injury or sickness:

| Name | Address | Telephone # | Dates of Treatment |
|---|---|---|---|
| Aleeza Parkey, Safe Haven Wellness Locust Grove, GA 30248. | | 404-987-8695 | April 2020- ongoing |

D. List the name, address, telephone number, and dates of treatment of all hospitals and/or facilities where you have received treatment for this injury or sickness:

| Name | Address | Telephone # | Dates of Treatment |
|---|---|---|---|
| N/A | | | |

E. List all your prescribed medications and dosages and the name, address, and telephone number of all pharmacies you use:

| Medications and Dosages | Name of Pharmacy | Address | Telephone # |
|---|---|---|---|
| Tremfya | Wegmans Pharmacy | 2873, Cheektowaga, NY 14227 | 866-889-5660 |

4. **Individual Disability Income Policy Premium Payments:**

**Berkshire Life Insurance Company of America assumes no liability for errors in reporting of tax liability and reliance thereon for tax withholding. Berkshire Life Insurance Company of America offers no tax advice. Please consult your tax advisors if questions arise.**

Notice: Pursuant to Federal Law and IRS Regulations, your benefits may be subject to mandatory Social Security and Medicare Tax withholding (FICA). Benefits paid, proportionate to any premium paid with employer or pre-tax dollars, may have FICA withheld. Any taxes withheld will be reported to your employer monthly and at year-end for inclusion with your Employer issued W-2 Form. Berkshire Life Insurance Company of America will not issue you a W-2.

Please check the situations below that describe who paid what percentage of premium over the past year on your individual disability income policy. Please provide applicable information on an additional page if you have more than five policies.

| | | Check all boxes that apply | Please provide policy numbers and indicate % of premium paid. Policy # | Policy # | Policy # | Policy # | Policy # |
|---|---|---|---|---|---|---|---|
| Not Subject to FICA withholding | A | ☑ Yourself with after-tax dollars | Z4834040 | | | | |
| | B | ☐ Your Sole Proprietorship | | | | | |
| | C | ☐ Your Partnership | | | | | |
| | D | ☐ Your S Corporation and you are a more than 2% owner | | | | | |
| | E | ☐ Your C Corporation but the value of the premium payments has been included in your gross salary | | | | | |
| Subject to FICA Withholding | F | ☐ Yourself with pre-tax dollars | | | | | |
| | G | ☐ Your employer and you have no ownership interest in that employer | | | | | |
| | H | ☐ Your S Corporation and you have a 2% or less ownership interest | | | | | |
| | I | ☐ Your C Corporation | | | | | |

Berkshire Life Insurance Company of America will rely on the information above in determining whether FICA will be withheld.

Sections **A through E:** your benefits, proportionate to the percentage of premium paid, **are not** subject to FICA withholding.

Sections **F through I:** your benefits, proportionate to the percentage of premium paid, **are** subject to FICA withholding.

**Please attach a copy of your last pay stub for the period just before disability onset.**

5. **Other Benefits**

A. List all other companies with which you are insured for Disability (Health) and/or Medical Benefits (if "none," so state)

| Company | Policy No. | Type of Coverage | Group/ Individual | Effective Date of Coverage | Amount of Benefits (State Weekly or Monthly) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

B. List all other benefits for which you are eligible, have applied, or you are now receiving:

| | Applied Yes | Applied No | Receiving Yes | Receiving No | Eligible Yes | Eligible No | Date Applied For | Amount Received Weekly | Amount Received Monthly | Effective Date |
|---|---|---|---|---|---|---|---|---|---|---|
| (1) Social Security (Self) | ☐ | ☐ | ☐ | ☐ | ☐ | ☑ | | | | |
| If denied, have you reapplied? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | | | |
| Social Security (Family) | ☐ | ☐ | ☐ | ☐ | ☐ | ☑ | | | | |
| If denied, have you reapplied? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | | | |
| (2) Workers' Compensation | ☐ | ☐ | ☐ | ☐ | ☐ | ☑ | | | | |
| (3) State Disability Insurance | ☐ | ☐ | ☐ | ☐ | ☐ | ☑ | | | | |
| (4) Retirement or Pension | ☐ | ☐ | ☐ | ☐ | ☐ | ☑ | | | | |
| (5) Salary Continuation | ☐ | ☐ | ☐ | ☐ | ☐ | ☑ | | | | |
| (6) Unemployment | ☐ | ☐ | ☐ | ☐ | ☑ | ☐ | | | | |
| (7) Government Retirement | ☐ | ☐ | ☐ | ☐ | ☐ | ☑ | | | | |
| (8) Union | ☐ | ☐ | ☐ | ☐ | ☐ | ☑ | | | | |
| (9) Other, e.g. Mortgage or Credit Protection | ☐ | ☐ | ☐ | ☐ | ☐ | ☑ | | | | |

**Important: All Information should be for your normal work week immediately before your injury or sickness.**

6. Occupation (or Occupations) Title Project Analyst

7. **Employer**

a) Name (If self-employed, state business name) Voya Financial through Opusing Staffing agency
b) Address Voya:5780 Powers Ferry Rd NW Atlanta GA 30327, Opusing: 101 Federal St Suite 1900, Boston, MA 0211[illegible]
c) Telephone No. Voya: 860-580-2780 Opusing: 781-574-0039
d) Name of immediate supervisor Jaclyn Faller May we contact this person? ☑ Yes ☐ No

8. **Business**

a) Do you have ownership interest in this business? ☐ Yes ☑ No
If Yes, what is the percentage of ownership at onset of injury or sickness? N/A %
b) Does any family member have any ownership interest in this business? ☐ Yes ☐ No
If Yes, please give name, relationship, and percentage of ownership interest of each family member.

| Name | Relationship | % Ownership Interest |
|---|---|---|
| | N/A | |

c) Type of Business Entity: ☑ C Corporation ☐ Sub S Corporation ☐ Partnership ☐ Sole Proprietor ☐ Other

d) Type of Business:
(i) product(s) produced N/A
(ii) service(s) produced Financial Services

e) Do you have any ownership interest or work activities in any other business(es) and/or for any other employer?
☐ Yes ☑ No
If Yes, please provide details

9. Are you or your business(es) currently involved in or contemplating filing for bankruptcy? ☐ Yes ☑ No

10. a) Average number of hours worked each week: 45
b) Usual daily hours: from 8 ☑ a.m. ☐ p.m. to 5 ☐ a.m. ☑ p.m.
c) Days of the week worked: ☑ Mon ☑ Tues ☑ Weds ☑ Thurs ☑ Fri ☐ Sat ☐ Sun

11. Gross earned income prior to injury or sickness (before taxes, after business expenses) $ 7,600 /per month

12. a) Number of people you employ 0
    b) Number of independent contractors you engage 0
    c) Number of people under your supervision 0

13. a) Years with current employer (or, if self-employed, years in current business) 3.5 years
    b) Years in this occupation 10

14. **Occupational Duties (list in order of importance)**

| | Duty | Description | Hours Per Week |
|---|---|---|---|
| a) | Reporting | Preparing data reports for senior executives | 45 |
| b) | | | |
| c) | | | |
| d) | | | |
| e) | | | |

15. **Instruments, Tools or Equipment normally used by you in your occupation**

| | Description | Purpose | Hours Per Week |
|---|---|---|---|
| a) | Keyboard, monitors, mouse, desk, chair | | 45 |
| b) | | | |
| c) | | | |
| d) | | | |
| e) | | | |

16. **Travel**

Does your occupation (or occupations) normally require travel other than between residence and principal place of business? ☐ Yes ☑ No

If Yes, please describe usual frequency, mode of transportation and average trip distance.

N/A

17. a) Is there a position description for your job? ☐ Yes ☑ No
    b) Do you receive periodic performance reviews of your work? ☐ Yes ☑ No
    c) Please attach all available position descriptions, performance reviews, resumes and curricula vitae.

18. Do you require a license to conduct your job? ☐ Yes ☑ No If Yes, please provide:
    a) Type of license(s) N/A
    b) License and/or certificate number(s) and state(s) N/A
    c) Are all your licenses current and in good standing? ☐ Yes ☐ No If No, please provide detailed explanation.

N/A

19. Are there any complaints, actions, or investigations pending involving you? ☐ Yes ☑ No

20. Have you ever been the subject of a work-related disciplinary action or investigation? ☐ Yes ☑ No

If Yes to questions 19 or 20, please provide detailed explanation.

N/A

21. Dominant Hand: ☑ Right ☐ Left

22. Work Conditions/Responsibilities (check all that apply)
    ☑ Works Alone ☑ Works on a Team ☐ Works Around Others ☑ Works at Home ☐ Contact with Public
    ☐ Any Protective Equipment?

23. **Requirements of your occupation (Check one or more of the following, which apply and best describe the demands of your occupation).**

| In terms of an 8-hour work day, I am required to: | | | | |
|---|---|---|---|---|
| **Check Here for all that apply** | **Occasionally** 1/4 – 1 1/2 hrs. | **Frequently** 1 1/2 - 5 hrs. | **Constantly** 5 - 8 hrs. | **I cannot currently perform this task due to disability** |
| ☐ Reach | ☐ | ☐ | ☐ | ☐ |
| ☐ Twist Neck | ☐ | ☐ | ☐ | ☐ |
| ☐ Twist Body | ☐ | ☐ | ☐ | ☐ |
| ☑ Walk | ☐ | ☑ | ☐ | ☐ |
| ☑ Stand | ☐ | ☑ | ☐ | ☐ |
| ☑ Sit | ☐ | ☐ | ☑ | ☐ |
| ☐ Kneel | ☐ | ☐ | ☐ | ☐ |
| ☐ Squat | ☐ | ☐ | ☐ | ☐ |
| ☐ Crawl | ☐ | ☐ | ☐ | ☐ |
| ☐ Drive | ☐ | ☐ | ☐ | ☐ |
| ☐ Climb Stairs | ☐ | ☐ | ☐ | ☐ |
| ☐ Climb Ladder | ☐ | ☐ | ☐ | ☐ |
| ☐ Climb Other (Explain) | ☐ | ☐ | ☐ | ☐ |
| ☐ Manipulate Objects With Left Hand | ☐ | ☐ | ☐ | ☐ |
| ☐ Manipulate Objects With Right Hand | ☐ | ☐ | ☐ | ☐ |
| ☑ Manipulate Objects With Both Hands | ☐ | ☐ | ☑ | ☐ |
| ☑ Fine Finger Dexterity | ☐ | ☐ | ☑ | ☐ |
| ☑ Enter Data/Keystroke | ☐ | ☐ | ☑ | ☐ |
| ☐ Use Foot Pedals | ☐ | ☐ | ☐ | ☐ |
| ☑ Speak – Express or Exchange Ideas Orally | ☐ | ☐ | ☑ | ☑ |
| ☑ Hear – Recognize Sounds | ☐ | ☐ | ☐ | ☐ |
| ☑ Use Sight-Near Vision | ☐ | ☐ | ☐ | ☐ |
| ☐ Use Sight-Far Vision | ☐ | ☐ | ☐ | ☐ |
| ☑ Perform Complex Problem Solving | ☐ | ☐ | ☑ | ☑ |
| ☑ Interact With People/Clients | ☐ | ☐ | ☑ | ☑ |
| ☑ Perform Written/Oral Communication | ☐ | ☐ | ☑ | ☑ |
| ☐ Other (Explain) | ☐ | ☐ | ☐ | ☐ |
| ☐ Lift | ☐ | ☐ | ☐ | ☐ |
| If Required, How Much Weight? _____ lbs. Frequently; _____ lbs. Maximum | | | | |
| ☐ Carry | ☐ | ☐ | ☐ | ☐ |
| If Required, How Much Weight? _____ lbs. Frequently; _____ lbs. Maximum | | | | |
| ☐ Push/Pull With Arms | ☐ | ☐ | ☐ | ☐ |
| If Required, How Much Weight? _____ lbs. Frequently; _____ lbs. Maximum | | | | |
| ☐ Push/Pull With Legs | ☐ | ☐ | ☐ | ☐ |
| If Required, How Much Weight? _____ lbs. Frequently; _____ lbs. Maximum | | | | |

24. **Previous Work History**

| | **Employer** | **Occupation Title** | **Duties/Responsibilities** | **From** | **To** |
|---|---|---|---|---|---|
| a) | Kohl, Target, Regus & Allied Security | | All temporary employment of less than 30 days between 2018 and 2019 | | |
| b) | | | | | |
| c) | | | | | |

25. Identify all work activities performed since disability began (include all profit and not for profit activities).

N/A

26. Education/Training (check all that apply)
☐ GED ☐ High School Diploma ☐ Trade School Certificate ☐ College (undergraduate degree)
☑ College (advanced degree) ☐ Currently Enrolled
If currently enrolled, please provide name, address of school or college and dates of enrollment.

27. Professional Insurance (i.e., Malpractice, Errors and Omissions, General Liability, etc.) - include carrier name(s), address(es) and policy number(s).

N/A

I declare that all answers, statements and information made or given by me, or at my direction, in connection with this claim are and have been complete and true. I further understand Berkshire Life Insurance Company of America or its representative(s) may request from time to time any documents which I have in my possession, supporting this statement, and I hereby agree to furnish them upon request.

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a fraudulent insurance act, which may be a crime, and may also be subject to civil penalties or denial of insurance benefits.

04/24/2023
Date

Wairimu Waiyaki
Signature of Insured